STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005109	A. BUILDING _____ B. WING _____	06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY HOSPITAL SOUTH	1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State complaint survey. Complaint Number: IN00106141 Unsubstantiated; lack of sufficient evidence Survey Date: 6-14-12 Facility Number: 005109 Surveyor: Jack I. Cohen, MHA Medical Surveyor Community Hospital South was found in compliance with the 410 IAC 15-1.5-2, Infection control and 15-1.5-8, Physical plant, environment and maintenance requirements for licensure rules. QA: claughlin 06/22/12	S 000		